

AUTO INSURANCE VERIFICATION

I, _____, authorize my insurance agent/company to disclose the following information to _____ for the purpose of _____.

Signature _____ **Date** _____

Print Name _____

INSURANCE AGENT: Please fill out and return to:

Fax Number _____ **or E-Mail** _____

THIS AREA TO BE COMPLETED BY THE INSURANCE AGENT

Insured Individual's Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Insurance Company: _____ **Phone:** _____

Agent Contact Name: _____ **Fax:** _____

Policy Start Date: _____ **Policy End Date:** _____

Is there liability for injuries or damage to a third (3rd) party? ☐ Yes ☐ No

Does the coverage cover the insured individual in an accident? ☐ Yes ☐ No

Does the coverage pay for damage done to rental vehicles? ☐ Yes ☐ No

Policy Number: _____ **Expiration:** _____

Agent's Signature _____

Date _____

